YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include completed Consent in the patient's chart.

callan EYE CARE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFO

Patient Information

SECTION A: PATIENT GIVING CONSENT (Please Print)

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Social Security#: _____

E-mail: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Dr. Anthony J. Callan Address: 65 N. 3rd Street, Easton, PA 18042

Telephone: 610-253-6135 Fax: 610-253-8945 E-mail: callaneyecare@hotmail.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representation on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

MEDICAL INFORMATION RELEASE FORM

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Patient Information

HIPAA Release Form

Patient Name: _____ DOB: _____

Release of Information

[ ] I authorize the release of information including the diagnosis records; examination rendered to me and claims information. This information may b released to:

[ ] Spouse: _____

[ ] Child(ren): _____

[ ] Other: _____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number

If unable to reach me

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] Other: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

65 North 3rd Street, Easton PA, 18064 | (610) 253-6911 | www.callaneyecare.com

Monday — Thursday: 9am — 5pm | Friday: 9am — 1pm

INSURANCE RESPONSIBILITY

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Patient Information

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or procedure to be "not covered," you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

Patient/Guardian Signature: _____ Date: _____